

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1234

1. PLACE OF DEATH

County Jackson
 Township Raw
 City Kansas City, Mo. (No. Gen. Hospital #1)

Registration District No. 309Primary Registration District No. 5002File No. 272

Registered No. _____

St. _____ Ward _____

2. FULL NAMEBell Clapper

(a) Residence. No. 1114 - E. 16th St. St. 4 Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS**3. SEX**Female**4. COLOR OR RACE**Colored**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**Married**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF****6. DATE OF BIRTH (MONTH, DAY AND YEAR)**Unknown**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

La.**10. NAME OF FATHER**Cress Coffey**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

La.**12. MAIDEN NAME OF MOTHER**Louise Green**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

La.**14.**

INFORMANT

(Address)

Record ClarkGeneral Hosp #2**15.**

FILED

1/23/32W. M. Crayne

REGISTRAR

MEDICAL CERTIFICATE OF DEATH**16. DATE OF DEATH (MONTH, DAY AND YEAR)**Jan. 10 1932**17.**

I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1932, to Jan. 10, 1932.
 that I last saw him alive on Jan. 10, 1932, and that death occurred, on the date stated above, at 8:05 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:Cerebral Apoplexy10882 A (duration) yrs. mos. ds.CONTRIBUTORY (SECONDARY) Hypostatic PneumoniaLobar (duration) yrs. mos. ds.**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF 1/11/32WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Ch. & Job(Signed) Quinn Miller, M. D., 19 (Address) Gen. Hosp. #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Westlawn1-23-32**20. UNDERTAKER**

ADDRESS

Nathan W. Hatcher1520 E. 25

